STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E015	A. BUILDING _____ B. WING _____	C 06/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRISELL MEMORIAL HOSPITAL LTCU	330 S VERMONT PO BOX 268 RANSOM, KS 67572

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The following citations represent the findings of complaint investigation #87785 and #87571.	F 000		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This Requirement is not met as evidenced by: The facility had a census of 26 residents. The sample included 4 residents. Based on observation, record review and interview the facility failed to provide necessary care and services by lack of accurate and complete assessments, for 1 of 4 sampled residents, after he/she received abrasions to his/her toes on his/her left foot.(#1) Findings included: - The 6/1/15 physician order sheet indicated Resident #1 had diagnoses of restless leg syndrome (a disorder of the part of the nervous system that causes an urge to move the legs), parkinsons (a slowly progressive neurologic disorder characterized by resting tremor, rolling of the fingers, masklike faces, shuffling gait, muscle rigidity and weakness), dementia(a progressive mental disorder characterized by failing memory, confusion) and history of stroke (when the blood supply to part of your brain is interrupted or severely reduced, depriving brain tissue of oxygen and nutrients. Within minutes, brain cells	F 309		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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F 309	Continued From page 1 begin to die). The quarterly (MDS) Minimum Data Set assessment, dated 4/1/15, indicated the resident had a (BIMS) Brief Interview for Mental Status score of 3, which indicated severe cognitive impairment. The MDS indicated the resident required total staff assistance with (ADLs) Activities of Daily Living, upper and lower extremity impairment on both sides, and used a wheelchair for mobility. The 4/9/15 care plan indicated the resident had limited vision, required total staff assistance with ADLs, and transferred with a full lift. The care plan directed the staff to monitor the resident's skin with bathing and when providing cares to the resident. The care plan indicated he/she was a large resident, stiffens his/her body when staff try to reposition him/her, becomes restless at times, scoots on his/her bottom and slides down, when sitting in a chair. The care plan directed the staff to monitor the resident for skin breakdown. The 6/4/15 facility report indicated the resident, while seated in the whirlpool chair, received abrasions to his/her 2nd, 3rd, and 4th toes while being transported, by the staff, to the whirlpool room. The 6/4/15 skin assessment indicated the resident's 2nd toenail on his/her left foot had a bruise with dried blood, the 3rd and 4th toe had glazed skin. The nurse cleansed the areas and left them open to air. (the assessment lacked documentation of the size or description of the areas) The 6/9/15 skin assessment indicated the areas on the resident's toes were scabbed, no signs of	F 309		

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F 309	Continued From page 2	F 309		

infection and the nurse would continue to monitor. (the assessment lacked documentation of the size or description of the areas.)

The 6/9/15 at 5:00 PM nurse's note indicated, on 6/3/15, the nurse assessed the resident's feet and found blood on three toes of the resident's left foot. The note indicated the nurse cleansed the resident's toes with normal saline and applied a band aid to the toes.

The 6/16/15 skin assessment indicated the areas on the resident's toes were scabbed, intact, no signs of infection, and the nurse would continue to monitor. (the assessment lacked documentation of the size, or complete description of the areas.)

On 6/16/15 at 2:45 PM, observation revealed Administrative Nurse A removed the sock from the resident's left foot which revealed an approximately 1 (cm) centimeter scabbed area, on the tip of his/her 2nd toe, and approximately 1-2 cm scabbed area on the top of his/her 3rd and 4th toes. Further observation revealed the toes were pink.

On 6/16/15 at 1:28 PM, Nurse Aide B stated the resident had stiff legs and was unable to bend his/her knees to allow the resident's feet to sit upon the whirlpool chair's foot rests causing his/her feet to hang down, touching the floor. Nurse Aide B verified on 6/3/15, he/she propelled the resident down the hall, on a whirlpool chair, to the whirlpool room, and ran over the toes of the resident's left foot. Nurse Aide B further stated he/she removed the resident's shoes and socks in the whirlpool room, looked at the resident's toes and did not see any blood. Nurse Aide B stated he/she continued with the resident's

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F 309	Continued From page 3 whirlpool. Nurse Aide B stated when he/she had finished with the resident's whirlpool and was getting the resident out of the whirlpool, he/she noticed the resident's left foot toes were bleeding and notified the nurse. On 6/16/15 at 3:51 PM, Nurse C verified the staff were not measuring the abrasions on the resident's left foot toes and stated they should be measuring and documenting the areas. On 6/16/15 at 3:58 PM, Administrative Nurse A stated he/she would expect the staff to measure and describe the resident's abrasions on his/her toes, on the left foot, weekly, and document them on the skin assessment sheet. The facility's 3/11 Special Care of Skin policy instructed the nurse to conduct a complete skin assessment of the resident as needed. The facility failed to provide necessary care and services by not completing accurate assessments, including size and description of Resident #1's abrasions to his/her toes.	F 309		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This Requirement is not met as evidenced by: The facility had a census of 26 residents. The sample included 4 residents. Based on	F 323		

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F 323	Continued From page 4 observation, record review and interview the facility failed to identify environmental hazards, which resulted in an avoidable accident for 1 of 4 residents reviewed for accidents. A nurse aide ran over Resident #1's toes with the whirlpool chair, failed to have a nurse assess the resident's toes, proceeded to provide the resident a whirlpool bath and the resident sustained abrasions (scraping or rubbing away of a surface, such as skin, by friction) to his/her left foot toes. Findings included: - The 6/1/15 physician order sheet indicated Resident #1 had diagnoses of restless leg syndrome (a disorder of the part of the nervous system that causes an urge to move the legs), parkinsons (a slowly progressive neurologic disorder characterized by resting tremor, rolling of the fingers, masklike faces, shuffling gait, muscle rigidity and weakness), dementia(a progressive mental disorder characterized by failing memory, confusion) and history of stroke (when the blood supply to part of your brain is interrupted or severely reduced, depriving brain tissue of oxygen and nutrients. Within minutes, brain cells begin to die). The quarterly (MDS) Minimum Data Set assessment, dated 4/1/15, indicated the resident had a (BIMS) Brief Interview for Mental Status score of 3, which indicated severe cognitive impairment. The MDS indicated the resident required total staff assistance with (ADLs) Activities of Daily Living, upper and lower extremity impairment on both sides, and used a wheelchair for mobility. The 4/9/15 care plan indicated the resident had limited vision, required total staff assistance with	F 323		

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F 323	Continued From page 5	F 323		

ADLs, and transferred with a full lift. The care plan directed the staff to monitor the resident's skin with bathing and when providing cares to the resident. The care plan indicated the resident was a large person, and stiffens his/her body when staff try to reposition him/her. The care plan directed the staff to monitor the resident for skin breakdown. The care plan indicated the resident becomes restless at times, scoots on his/her bottom and slides down, when sitting in a chair.

The 6/4/15 facility report indicated the resident, while seated in the whirlpool chair, received abrasions to his/her 2nd, 3rd, and 4th toes while being transported, by the staff, to the whirlpool room.

The 6/4/15 skin assessment indicated the resident's 2nd toe nail had a bruise with dried blood, the 3rd and 4th toe had glazed skin. The nurse cleansed the areas and left them open to air. (the assessment lacked documentation of the size or description of the areas)

The 6/9/15 skin assessment indicated the areas on the resident's toes were scabbed, no signs of infection and the nurse would continue to monitor. (the assessment lacked documentation of the size or description of the areas.)

The 6/9/15 at 5:00 PM nurse's note indicated, on 6/3/15, the nurse assessed the resident's feet and found blood on three toes of the resident's left foot. The note indicated the nurse cleansed the resident's toes with normal saline and applied a band aid to the toes.

The 6/16/15 skin assessment indicated the areas on the resident's toes were scabbed, intact, no signs of infection, and the nurse would continue

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F 323	Continued From page 6	F 323		

to monitor. (the assessment lacked documentation of the size, or complete description of the areas.)

On 6/16/15 at 2:45 PM, observation revealed Administrative Nurse A removed the sock from the resident's left foot which revealed an approximately 1 (cm) centimeter scabbed area, on the tip of his/her 2nd toe, and approximately 1-2 cm scabbed area on the top of his/her 3rd and 4th toes. Further observation revealed the toes were pink.

On 6/16/15 at 1:28 PM, Nurse Aide B stated the resident had stiff legs and was unable to bend his/her knees to position his/her feet on the whirlpool chair's foot rests, causing his feet to hang down, touching the floor. Nurse Aide B verified on 6/3/15, he/she propelled the resident down the hall, on a whirlpool chair, to the whirlpool room, and ran over the resident's toes of the left foot. Nurse Aide B further stated he/she removed the resident's shoes and socks in the whirlpool room, looked at the resident's toes and did not see any blood. Nurse Aide B stated he/she continued with the resident's whirlpool. Nurse Aide B stated when he/she had finished with the resident's whirlpool and was getting him/her out of the whirlpool, he/she noticed the resident's left foot toes were bleeding and notified the nurse.

On 6/16/15 at 3:51 PM, Nurse C stated he/she would expect staff to notify the nurse right away when the accident with the whirlpool chair occurred, causing abrasions to the resident's left foot toes.

On 6/16/15 at 3:58 PM, Administrative Nurse A verified the accident occurred on 6/4/15, when

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F 323	Continued From page 7 staff transported the resident, on a whirlpool chair, to the whirlpool room. Administrative Nurse A stated staff should immediately report any incident involving a resident, to the nurse. On 6/22/15 at 12:00 PM, Administrative Nurse A stated the facility had no documentation regarding use of the whirlpool chair to transport the resident to the whirlpool room. On 6/22/15 at 2:30 PM, Administrative Nurse A stated the resident could bend his/her knees with assistance from the staff but could not bend them far enough back to stay on the foot rests of the whirlpool chair. The 10/12 facility Orientation checklist policy stated when a reportable (an incident causing injury to a resident) incident is identified, the person with knowledge of the incident completes the variance report for the risk management program. The facility failed to identify environmental hazards, including the potential for accidents for Resident #1, who's body was stiff due to parkinsons, and he/she was unable to be safely positioned on the whirlpool chair, causing injury to the resident's toes.	F 323		